

N.C. Department of Health and Human Services
Division of Medical Assistance
Breast and Cervical Cancer Medicaid Application

SECTION I. Answer the questions in Section I to determine if application needs to be completed for woman needing help with medical bills.

1. Person has been enrolled in and screened under the North Carolina Breast and Cervical Cancer Control Program and needs treatment for breast or cervical cancer including pre-cancerous conditions and early stage cancer. (***Definition of pre-cancerous condition for cervical cancer: High Grade Squamous Intraepithelial Lesion [HGSIL]).***
☐ **Yes** - Continue to question 2.
☐ **No** - The woman is ineligible for Breast and Cervical Cancer Medicaid. **STOP! Go no further.**
2. Person is age 18 through age 64.
☐ **Yes** -Continue to question 3.
☐ **No** -The woman is ineligible for Breast and Cervical Cancer Medicaid. **STOP! Go no further.**
3. Is this person a U.S. citizen, lawful permanent resident (admitted to the U.S. more than 5 years ago) or a refugee from another country?
☐ **Yes** -Make copies of INS documentation and cards (I-94, I-551, etc.) and attach with application if person is LPR or refugee. Continue to question 4.
☐ **No** - The woman is ineligible for Breast and Cervical Cancer Medicaid. **STOP! Go no further.**
4. Person has major medical insurance, which is defined as current coverage under a group health plan, including authorized for Medicaid and/or Medicare Part A or B, health insurance coverage (either individual or group), a military-sponsored health care program, a state health risk pool. Check Yes (she has insurance) or No (she does not have insurance.)
☐ **Yes** - The woman is ineligible for Breast and Cervical Cancer Medicaid, UNLESS coverage consists solely of limited benefits such as accidents or limited-scope dental, vision, or long-term care insurance. There may also be limited circumstances where a woman has major medical insurance, but she is not actually covered for treatment of breast or cervical cancer. If you have a question about an insurance policy call the State Medicaid Eligibility Unit at (919) 857-4019.
 - ❖ If the woman has limited medical insurance coverage, make a copy of the Insurance Card (front and back). Attach the copy to this application. Continue to question 5.
 - ❖ If coverage is not limited, **STOP! Go no further. This person is ineligible.**☐ **No** - Continue to question 5.
5. **Is this person any of the following: (Check Yes or No)**
 - A.) Pregnant ☐ **Yes** ☐ **No**
 - B.) Blind ☐ **Yes** ☐ **No**
 - C.) Disabled (determined by Social Security) ☐ **Yes** ☐ **No**
 - D.) Aged 18-20 ☐ **Yes** ☐ **No**
 - E.) A caretaker relative of children in the home under age 19 who are currently receiving Medicaid or North Carolina Health Choice? ☐ **Yes** ☐ **No**
If yes, list their names and dates of birth.

If the answer is "**No**" to all the questions in 5 A-E, **complete Section II only**, for applicant identifying information. Have the applicant and the person completing the form sign and date the application. This application is only for Breast and Cervical Cancer Medicaid Coverage.

If "**YES**" to any of the questions in 5A-E, **continue with Section II and Section III** of this application. Person may be eligible for another Medicaid program.

SECTION II. Information on Applicant

Name of Applicant

First Middle Initial Maiden Last

Home Address

Street Address or P.O. Box City State Zip County

Home Telephone # or # where applicant can be reached during the day

Social Security # Date of Birth (/ /)

Applicant status: (Check current status)

☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Race (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White

Ethnicity (Check yes or no) Hispanic or Latino ☐ Yes ☐ No

Language Preference (Check one) ☐ English ☐ Spanish ☐ Other

Retroactive Coverage-Does applicant need help paying medical bills for herself for the past three months prior to the date of this application?

☐ Yes ☐ No

If yes, please complete the information below. Medicaid may be able to help with those bills.

Name of doctor, clinic, or hospital where the person was seen	Date of medical treatment

Applicant's Acknowledgement

- I either read, or had read to me all parts of this application and I understand my rights and responsibilities as an applicant/recipient. Rights and Responsibilities are on the last page of this application.
- I authorize the release of any information necessary to establish my eligibility. This release is good for one year from the date of this application.
- This authorization to release information may be reproduced.
- All information I give is confidential.
- I attest that all statements recorded on this document are true and correct to the best of my knowledge.

Applicant needs to read rights and responsibilities on the last page of the application before signing.

Applicant's Signature Date

Signature of Screening Provider Completing Form Title

Medicaid Provider Number

Telephone #

Fax completed application and completed DMA-5081, Verification of Screening and Diagnosis for Breast and Cervical Cancer Medicaid to (919) 715-8548. Mail original to DMA.

DMA-5079

SECTION III. Complete this section if applicant answered YES to A, B, C, D, or E on question #5 in Section I.

INCOME- List income earned by applicant and her spouse. Income includes wages, tips, or salary received by applicant and her spouse who works. **Attach copies of last month's paystubs.** (Last month is the month prior to the date application completed.) Provide copies of current business records for the past 6 months if self-employed (or past 12 months if income is received annually).

List name of person working	Employer's name or type of business if self-employed	How often paid? Monthly, Weekly, etc.	Gross amount (before any taxes or deductions)

BENEFITS - Unearned income such as Social Security, SSI, Unemployment benefits, retirement benefits, child support, private or employer sponsored disability etc. Provide copies of check, award letters, or other proof of this income.

Benefits- Child Support, SSA, SSI, UIB, etc. List name of person receiving.	List where income is from. (EX: Child Support, Social Security)	How Often Received? Monthly, Weekly, etc.	Gross Amount

Does applicant or spouse pay child support for a child who is not in the home? ☐ Yes ☐ No

Who pays the support? _____ Amount paid? _____ How Often? _____

Was this person ordered by the court to pay support? ☐ Yes ☐ No

Does applicant or spouse pay child care or care for an incapacitated adult? ☐ Yes ☐ No

How much is paid? _____ How Often? _____

RESOURCES

Does applicant or her spouse have any of the following? (Check Yes or No) DMA will complete verifications column.

SOURCE	YES	NO	Whose/Where Located?	Value	Verifications
CASH					
CHECKING					
SAVINGS					
CD'S					
STOCKS/BONDS					
TRUST FUNDS					
REAL PROPERTY/HOME					
HEIR or OTHER PROPERTY					
FARM/BUSINESS					
BURIAL CONTRACTS					
PERSONAL PROPERTY (i.e. BOATS, CAMPERS, ETC.)					
OTHER					

Does applicant or spouse have any cars? - ☐ YES ☐ NO

(DMA Will Complete Last 2 columns)

MAKE	MODEL	YEAR	OWNER	VALUE	VERIFICATION

Does applicant or spouse have life insurance policies? ☐ Yes ☐ No If yes, list below.

Owner of policy	Policy Number	Name of Insurance Company	Face Value	Cash Value	Name of Insured

Double Check:

1. Page 2 of application is signed and dated by applicant.
2. All questions are answered.
3. "Rights and Responsibilities" given to applicant.
4. All verifications that are available are faxed and mailed with this form and DMA-5081 to DMA.

DMA-5079

Breast and Cervical Cancer Medicaid

“Rights and Responsibilities”

Notification of Decision

The State Division of Medical Assistance (DMA), Medicaid Eligibility Unit, will process your application for Breast and Cervical Cancer Medicaid coverage quickly. The sooner you get information we may need to DMA the sooner we can process your application for medical coverage. If additional information is needed you will be contacted by mail or telephone. Be sure to list correct phone numbers and address so you may be contacted.

Your Rights and Responsibilities

Rights:

- Apply for assistance and, if found ineligible may reapply at any time.
- Not be discriminated against because of race, color, national origin, sex, religion, age or disability.
- Have the information you provide kept in confidence.
- Withdraw from the program at any time.
- Receive assistance if found eligible.
- Appeal to the Division of Medical Assistance (State Medicaid Office) for a hearing if:
 - You were denied the right to apply for assistance.
 - You were encouraged to withdraw your application.
 - Your application was denied and you believe the decision is incorrect.
 - You believe your assistance is incorrect based on the state’s interpretation of state regulations.
- To ask for help with medical transportation, if found eligible for Breast or Cervical Cancer Medicaid. If transportation is provided, it will be to the nearest appropriate medical provider of your choice, by the least expensive method. To request transportation assistance contact your county department of social services.

Responsibilities:

- I agree to provide all necessary information to help county, state or federal Medicaid agencies determine my eligibility for this program.
- I agree to notify the Division of Medical Assistance (State Medicaid Office) within 10 calendar days of any changes in my address, plans to move, or availability of other health insurance or no longer receiving treatment for cancer. State Medicaid Eligibility Unit can be contacted through the CARE-LINE, toll-free 1-800-662-7030 or number for the Raleigh area (919) 857-4019.
- I agree to provide a social security number or apply for a social security number for myself, or anyone for whom I am applying for Medicaid, if one has not been issued.
- I certify that the information I have provided is a true and complete statement of facts. I understand that State and Federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance.
- I certify I currently live in North Carolina and intend to remain.